



Patient Name: _____ DOB: _____ Date: _____

PAST MEDICAL HISTORY

Please circle any conditions **YOU** have had in the past

GENERAL	LUNG/PULMONARY	GASTROINTESTINAL	GENITOURINARY
Appendicitis	Asthma	Colitis	Kidney Stones
Cancer: Type _____	Chronic Bronchitis	Gallstones	Urinary Tract Infections
Diabetes: Type _____	Emphysema	Hemorrhoids	Urinary incontinence
Epilepsy	Pneumonia	Hepatitis	Prostate Problems
High Blood Pressure	Tuberculosis	Indigestion/Heartburn	Sexually Transmitted Disease
High Cholesterol		Irritable Bowel Syndrome	
Migraine Headaches	CARDIOVASCULAR	Liver Disease	PSYCHIATRIC
Stroke	Aortic Aneurysm	Polyps	Depression
Thyroid Problems:	Bleeding Disorder	Ulcers	Anxiety
	Blood Clots	SKIN	BiPolar
	Heart Attack	Acne	Drug Abuse
CHILDHOOD DISEASES	Heart Disease	Bruise Easily	Alcoholism
Chicken Pox		Eczema	
Measles	MUSCULOSKELETAL	Melanoma	FEMALES ONLY
Mumps	Joint Pain	Psoriasis	Abnormal Pap Smear
Polio	Arthritis	EYE/EAR/NOSE/THROAT	Date of last Pap Smear: _____
Rheumatic Fever	Back Pain	Cataracts	Age at first menstrual cycle: _____
Scarlet Fever	Muscle Spasms	Glaucoma	Form of birth control: _____
	Gout	Ringling in Ears	Date of last mammogram: _____

Continued on the back

ALLERGIES (IE: MEDICATIONS, SHELLFISH, IODINE, BEE STINGS):

Family History: (please list any family members, including grandparents, aunts/uncles, siblings, parents or children)

Cancer (include type): _____
Hypertension: _____ High Cholesterol: _____
Heart disease: _____ Stroke: _____
Blood Clots: _____ Thyroid Problems: _____
Diabetes: _____ Type: _____ Kidney Disease: _____
Alzheimer's/Dementia: _____ Mental illness: _____

Do you have siblings? Yes or No Number of: Brothers _____ Sisters _____
Do you have kids? Yes or No Number of: Sons _____ Daughters _____

Family member:	Age or year of birth	Cause of death	
Father		<input type="checkbox"/> Living	<input type="checkbox"/> Deceased _____
Mother		<input type="checkbox"/> Living	<input type="checkbox"/> Deceased _____
Brother		<input type="checkbox"/> Living	<input type="checkbox"/> Deceased _____
Sister		<input type="checkbox"/> Living	<input type="checkbox"/> Deceased _____
Children:		<input type="checkbox"/> Living	<input type="checkbox"/> Deceased _____

SURGICAL HISTORY: (please include date of surgery or age at the time of surgery)

1. _____
2. _____
3. _____
4. _____

HOSPITALIZATION HISTORY: (Please include date, length of stay, and reason for hospitalization {not ER visits})

1. _____
2. _____
3. _____
4. _____

SOCIAL HISTORY:

Are you: Single Married Engaged Widowed Divorced Separated

Do you drink caffeine? Yes or No How many cups of coffee, tea, soda or energy drinks do you drink a day? _____
Smoking history: Non-smoker Former Smoker Current Smoker Chew Vape
If you smoke or chew: How much? _____ How long have you smoked or chewed: _____
Marijuana use: Yes or No How often? _____
Do you use illegal drugs: Yes or No If so, which one(s): _____
Do you drink alcohol: Yes or No If so, how much: _____
Occupation: _____
Highest level of education completed: _____ Who do you live with: _____



Name: _____ DOB: _____ Today's date: _____

Please list all medications you are currently taking below.

Medication	Strength	Dosage
Example: Naproxen	500mg	3 times daily
1.		
2.		
3.		
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30.		



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ Phone: _____

I hereby authorize the release of my medical records and confidential information as described below.

RELEASE FROM: <i>(individual, medical facility, school, agency, other)</i>	RELEASE TO: <i>(individual, medical facility, school, agency, other)</i>
Name:	Name: G Street Integrated Health
Address:	Address: 1435 G St, Springfield, OR 97477
Phone: _____ Fax: _____	Phone: 541-735-9420 Fax: 541-747-9870

I understand my records include medical records, treatment history, progress notes, summaries, medication history, lab reports, hospital, and immunization records. I understand that federal and/or state laws prohibit the re-disclosure of mental health, drug and alcohol, HIV/AIDS/STD diagnosis and treatment information. Specific authorization is required for the releases of such information as marked below.

Initial below to authorize these types of records to be released:

- Mental health records which may include referral information
- HIV/AIDS/STD related information and/or records
- Genetic testing information and/or records
- Drug and alcohol records including diagnosis, assessments, toxicology, psychotherapy/progress notes, treatment, attendance, and referral information

Indicate the reason for release:

- Continuity and/or coordination of care
- Transfer of care
- Legal proceedings

Specific information to be released:

- Any and all records *excluding Protected Health Information unless authorized above.*
- Other: _____

By signing below, I understand this agreement, and I am satisfied with any explanations I may have requested and received. This release is in effect for one year from the date of signing. For behavioral health records, this release only remains in effect for 30 days at the conclusion of services. I understand that information about my care is confidential and protected by state and federal law and I may cancel this authorization at any time. To cancel the authorization, I must provide a request in writing. The request to cancel this consent will not affect information that was released prior to the date of my cancellation request. I understand the person or organization receiving these records could re-disclose the records and they may not be covered under federal privacy laws.

Any information that has been disclosed from these records is protected by Federal Confidentiality Rules (42 CFR Part 2). Federal rules restrict the use of a general authorization to criminally investigate or prosecute any alcohol or drug abuse patient.

I have read the entire release and understand this authorization is voluntary and I may refuse to sign the authorization.

Signature: _____ Relationship to Patient: _____ Date: _____



G STREET

Integrated Health

Acknowledgment of Receipt of Notice of Privacy Practices Consent to Treat and Consent to Inform

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal health care operations such as quality assessments and physician certifications

I have been offered the *Notice of Privacy Practices* document containing a more complete description of the uses and disclosures of my health information. I understand that **G Street Integrated Health** has the right to change its *Notice of Privacy Practices* from time to time and that I may contact the organization at any time for a current copy of the *Notice of Privacy Practices* document.

Please mark the appropriate box below.

- Do you consent to be treated at this facility? Yes No
- Do you consent to the use of Electronic Scribe dictation technology? Yes No
- May we leave a detailed message on your voicemail or via text? Yes No
- Can we confirm appointments by leaving a voicemail or texts? Yes No

Who can we talk with about your care?

Name _____ Phone _____ Check here for none

_____	_____	_____
Patient Name	Signature	Date
_____	_____	_____
Guardian relationship	Signature	Date

FOR OFFICE USE ONLY

Practice provided the above-referenced patient with the Practice’s Notice of Privacy Practices and this Acknowledgment of Receipt of Notice of Privacy Practices, but could not obtain a signed acknowledgment form because:

- Patient or guardian refused to sign
- Emergency situation
- Other:
